Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02AL0180	A. BUILDING: _____ B. WING _____	C 10/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ANNAPOLIS	800 BESTGATE ROAD ANNAPOLIS, MD 21401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	Initial Comments On October 2, 2013, an unannounced complaint investigation was made to the above named facility for the purpose of determining the facility's compliance with COMAR 10.07.14. Survey activities included a review of resident records, facility documentation and an interview with the ALM. The facility's census at the time of the survey was 89 residents. Based on survey findings, in relation only to Complaint # MD00079061/ MD00075239, the facility was found to be in compliance with COMAR 10.07.14, the regulations governing assisted living programs.	E 000		

OHCQ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE